



Please complete this form and attach to the Health Delivery Organization Form if your organization is a DME Supplier or Pharmacy.

GENERAL INFORMATION

NAME OF DME SUPPLIER OR PHARMACY _____

DME SUPPLIER SERVICES

- Durable medical equipment and/or accessories (hospital beds, wheelchairs, walkers, etc.)
 - Oxygen and oxygen equipment
 - Orthotics (leg braces, arm braces, back braces, etc.)
 - Prosthetics (prosthetic lenses, artificial legs and arms, artificial eyes, etc.)
 - Medical supplies (catheters, feeding bags, colostomy bags, etc.)
 - Optical Dispensary
 - Hearing Aid Dealers
 - Specialty Pharmacy
 - Other services _____
- Of the above services, which one constitutes 50 percent or more of your business? _____

GENERAL QUESTIONS

1. In reference to durable medical equipment, do you:
 - Rent Only
 - Sell Only
 - Rent/Sell
2. Is free delivery and installation provided for rented or purchased equipment? Yes No
3. Is equipment repair and maintenance service provided for rented equipment? Yes No
4. Is seven day-a-week, 24-hour emergency service provided by technicians and clinicians? Yes No
5. Is warranty maintenance service provided by your company for purchased equipment? Yes No
(This includes manufacturer's warranties)
6. Are clinical professionals available to provide patient education and home management? Yes No
7. Has your company ever been sanctioned or suspended from receiving payment under the Medicare/Medicaid programs? Yes No
8. Has your company ever been denied liability coverage? Yes No

If you answered yes to questions #7 and/or #8, please give full details on a separate sheet.

ATTACH THIS FORM TO THE HEALTH DELIVERY ORGANIZATION APPLICATION

Mail the Health Delivery Organization Information Form and Attachment B to:

**Network Operations Department
Blue Cross and Blue Shield of Louisiana
P.O. Box 98029
Baton Rouge, LA 70898**